Title:
(b) (6), Lumpkin, GA

Case Number:
DHS Case # I17-ICE-ATL-15215

Case Agent: Special Agent (b) (6), (b)
Department of Homeland Security
Office of Inspector General
(b) (6), (b) (7)(C)
Atlanta, GA 30341
404-832-(b) Office
404-488-(b) Cell
(b) (6), (b) @oig.dhs.gov

Subject: (b) (6), (b)
(b) (6), (b)
(7)(C)

Criminal History:

1998-09-26; driving under influence (dui) 1st offense; misdemeanor

Background:

On May 17, 2017, the Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta Field Office, was advised that (b) (6), (b) Assistant Field Office Director (AFOD), Immigration and Customs Enforcement (ICE), at Stewart Detention Center (SDC), Lumpkin, GA, had notified DHS that the Georgia Bureau of Investigation (GBI) responded to SDC regarding the death of an inmate. The detainee, Jean Carlos Jimenez-Joseph (A#: (b) (6), (b)), was believed to have committed suicide by hanging himself in his detention cell. The GBI processed the involved cell. SDC is a privately managed detention facility ran by CoreCivic (CC) with oversight by ICE.

DETAILS:

On June 30, 2017, DHS OIG received policy documents from (b) (6), (b) (7)(C), SA, GBI, SDC, obtained during their investigation. SDC's Segregation/Restrictive Housing Unit Management policy was reviewed which stated that: *in accordance with ICE PBNDS 2.12 Special Management Units, ICE detainees in special management units (SNU) shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly (see Facility policy 9-105 Dry Cell Watches and/or CoreCivic Policy 13-84 Suicide Management).* (b) (6), (b) advised that video reviewed from SDC yielded that a random spot check was conducted at 11:58pm of Jimenez's cell by SDC supervisor, (b), and the next check was not until 12:43pm which was conducted by (b) (6), DHS OIG advised that due to the possible policy violation an investigation would be initiated. (Attachment A)

DHS OIG completed a review of documents received from the GBI to include video surveillance footage on 5/14/17 and 5/15/17; SDC handheld video response footage; miscellaneous cell surveillance footage; recorded telephone calls from SDC from March-May 2017; GBI reports. A review of the documents revealed the following:

On April 27, 2017, Jimenez-Joseph was placed in a segregation cell for 20 days. An incident report was reviewed which indicated that the segregation was due to Jimenez-Joseph jumping off a 2nd floor walkway down to the 1st floor. Additionally, on May 2, 2017, Jimenez-Joseph, received 3 additional days in confinement for exposing his penis to a SDC nursing staff member.

On May 15, 2017, at approximately 12:45 a.m., (b) (6), (b) (6), Detention Officer (DO) was completing a round count of Jimenez-Joseph's cell and observed him hanging by his neck from a bed sheet. The other end of the bed sheet was tied to a sprinkler head. Attempts to resuscitate Jimenez-Joseph were made by SDC staff until medical personnel arrived. Stewart County Emergency Medical Technicians (EMT) transported Jimenez-Joseph to Phoebe Sumter Medical Center (PSMC), Americus, GA, where he was pronounced deceased upon arrival. The SDC staff that assisted (b) were identified as: (b) Member of the SDC medical staff that responded to the incident were: Sl(b) (6), (b) (7)(C)

On May 15, 2017, (b) (6), (b) interviewed (b) (6), (b) (7) advised that in Segregation Unit 7A he was to conduct a round count every 30 minutes. Additionally, there were 4 inmates on a round count of 15 minutes. (b) stated that cell 102 was Jimenez-Joseph's cell, which was located in Unit 7A. (b) stated that on May 15, 2017, at approximately 12:45 a.m, he looked inside cell 102 and overserved Jimenez-Joseph slumped down with a "noose" tied over his neck. (b) then advised of the "Medical Emergency" via radio and went to obtain a "cut-down tool" from the control room. (b) successfully cut the "noose" and he and (b) (6), , the first DO on the scene, began CPR until medical staff

arrived, which took over attempts to revive Jimenez-Joseph for approximately 10 minutes until EMT's arrived.

On May 15, 2017, (b) (6), (b) (7), SA, GBI, interviewed (b) (6), (b) (7)(C), SDC, Lumpin, GA. (b) (6), advised that when Jimenez-Joseph arrived at SDC initial screening was conducted and in which Jimenez-Joseph stated he had a suicidal past, however, never showed any suicidal tendencies while he was at SDC. However, (b) (6), related that Jimenez-Joseph was being treated for a mood condition and was on prescription medications. (b) (6), said the last time she saw Jimenez-Joseph was on May 10, 2017, and related he was normal with no suicidal thoughts.

DHS OIG reviewed numerous detainee interview reports that were conducted by the GBI, none of which provided any information other than a detainee reporting that Jimenez-Joseph would jump up and down in his cell yelling "Julius Caesar." The inmate believed Jimenez-Joseph was having a mental episode.

Video surveillance from SDC was reviewed from 10 p.m. on May 14, 2017 through 2 a.m. on May 15, 2017 which encompassing the time frame of the incident. The following persons were identified being present on the video during that time frame:

A review of the video surveillance yielded the following time-line:

May 14, 2017 – May 15, 2017

10:14 p.m.: (b) 1st check of cell 102 (Jimenez-Joseph's cell).

11:00 p.m.: (b) (6), 1st check of cell 102.

11:02 p.m.: (b) 2nd check of cell 102.

11:25 p.m.: (b) 3rd check of cell 102.

11:58 p.m.: (b) (6), (b) (7) 1st check of cell 102.

12:43 a.m.: (b) 4th check of cell 102. (b) is observed looking through cell window numerous times and talking on a handheld radio. (b) exits Unit 7A. (b) (6), enters Unit 7A.

12:44 a.m.: (b) (6), 2nd check of cell 102 and stands at cell door until (b) re-enters Unit 7A and opens door of cell 102. (b) (6), (b) (7)(C) enter Unit 7A.

12:46 a.m: (b) (6), (b) (7)(C) enter Unit 7A with a stretcher. (b) (6), enters into Unit 7A.

12:46 a.m.- 12:58 a.m.: (b) (6), (b) (7)(C) enter into Unit 7A.

12:59 a.m.: EMT's (b) (6), (b) (7)(C) enter Unit 7A and enter cell 102.

1:14 a.m: Jimenez-Joseph observed being placed on a stretcher. (b) (6), can be observed performing chest compressions.

1:15 a.m – 1:16 a.m.: (b) (6), observed performing chest compressions on stretcher as Jimenez-Joseph was removed from Unit 7A along with SDC staff.

After reviewing the video it was determined by the GBI that there was a 45 minute span between when (b) (6), (b) conducted his 1st check of cell 102 at 11:58 p.m. and when (b) conducted his 4th check of cell 102 at 12:43 a.m. During that time is when the Jiminez-Joseph incident occurred.

On May 23, 2017, (b) (6), (b) contacted Free which was accompanied by several of Jimenez-Joseph's family members. Family members reported the following: Jimenez-Joseph acted like he had multiple personalities and had previously been admitted to the Mental Crisis Unit in Wake County, NC, on three occasions. Jimenez-Joseph tried to commit suicide by jumping off the 2nd story floor at SDC. Jimenez-Joseph attempted suicide two known times in the past, one attempt involved a rope. Jimenez-Joseph stated to a family member during a telephone call he was tired of SDC and tried to kill himself. Jimenez-Joseph also stated he would stay up all night yelling "get me out of here, I am Napoleon." Family members stated they realized Jimenez-Joseph was mentally unbalanced.

The DHS OIG reviewed call logs and transcribed telephone conversations made by Jimenez-Joseph in May of 2017 which yielded the following: Jimenez-Joseph stated in multiple conversations he heard voices; he was diagnosed with schizophrenia, bipolar disorder, psychosis and paranoia and stated he was taking Risperidone for treatment. Jimenez-Joseph stated his voice was hoarse from yelling at the top of his lungs for a long time. Jimenez-Joseph stated he was put in jail for 25 days because he jumped off the 2nd floor balcony and that he tried to hurt himself. He added that he tried to commit suicide because he was sick and tired of being at SDC. Jimenez-Joseph stated he was going to tell the judge about his mental disorder and he needed the family to conduct legal research so he could try to get relief from deportation for a mental disability.

The DHS OIG reviewed information indicating that (b) (6), (b) (7)(C) , GBI, Decatur, GA, performed the autopsy related to Jimenez-Joseph in which the cause of death was classified as a hanging and the manner of death was classified as a suicide. (b) (6), (b) (7) noted that the injuries to Jimenez-Joseph were consistent with a self-inflicted hanging. A toxicology report confirmed the presence of Risperidone in Jimenez-Joseph's system.

On July 27, 2017, the GBI stated that upon review of witness statements, crime scene processing, surveillance footage and the autopsy report the case by GBI was closed. (Attachment B)

On November 2, 2017, DHS OIG attended an audit review of the Immigration and Customs Enforcement (ICE), Health Services Corps (IHSC), SDC. The purpose of the review was to provide information to the IHSC and ICE, Enforcement and Removal (ERO), staff on internal audit findings, following the suicide of Jiminez-Joseph. The briefing was conducted by (b) (6), (b) (7)(C), IHSC, ICE, SDC. (b) (6), (b) provided details of Jimenez-Joseph's medical and mental history. According to (b) (6), (b), when Jimenez-Joseph was processed into the CC SDC facility he was a Priority #1, meaning he should have been seen immediately by IHSC, however he was not seen for five hours. In addition, (b) (6), (b) advised that no suicide assessment was conducted on Jimenez-Joseph, during the IHSC intake processing once he was seen by the IHSC. As a result of these findings, the prescreening policy has been changed. (b) (6), (b) indicated that the audit found issues with the suicide watch policy as it related to monitoring a person on suicide watch. (b) (6), (b) advised that the policy indicates once a detainee is placed on suicide watch, they must remain under continuous watch for a minimum of 24 hours. (b) (6), (b) explained that Jimenez-Joseph was taken off suicide watch before the mandatory timeframe elapsed without proper approval and outside the scope of IHSC policy. (b) (6), (b) indicated as a result of his past mental health issues of Jimenez-Joseph; hearing voices, etc., there was no way he was stable enough to be taken off of suicide watch, however IHSC records show he was cleared as "stable" when there is nothing stable about hearing voices. (b) (6), (b) stated the audit found the IHSC failed to properly diagnose Jimenez-Joseph as unstable and should have increased his medication dosage. (Attachment C)

(b) (6), (b) further explained that on the day he committed suicide, it was discovered that Jimenez-Joseph had a mental health appointments with IHSC, however it was rescheduled for three weeks later and he was never seen that day. As a result of the audit findings, (b) (6), (b) indicated that all IHSC staff needed to be retrained on how to handle mental health patients. (b) (6), (b) advised that on May 10, 2017, Jimenez-Joseph was found in ICE SDC, segregation pounding his head up against the wall and claiming to be hearing voices and reported to be having thoughts of killing himself. (b) (6), (b) advised that the audit found that Jimenez-Joseph was not added to the "significant" mental health lists. In addition, the audit found that Jimenez-Joseph jumped from the second tier of the SDC housing unit and IHSC staff was not notified of the incident. This should have been reported as an attempted suicide. (b) (6), (b) stated that the audit found after the Jimenez-Joseph suicide, the medical response by the IHSC was appropriate. Lastly, (b) (6), (b) advised that a weekly meeting with CC SDC management, IHSC and ICE ERO, had been implemented to try and prevent any miscommunication or lapses in policy and procedure in the future.

On November 2, 2017, DHS OIG interviewed (b) (6), (b) (7)(C), CoreCivic, Lumpkin, GA. DHS OIG was advised that one CC employee, was fired as a result of this incident. (b) advised that the employee was (b) (6), (b) advised that she was present during the termination of (b) (6), (b) indicated that (b) (6), (b) (7)(C) CC, SDC and (b) (6), (b) (7)(C), CC, SDC, were present as well and advised (b) of his termination. (b) provided a one page document labeled

"CoreCivic Facility Employee Problem Solving Notice" which (b) stated was provided to (b) (6), The document provided was reviewed by DHS OIG which indicated that (b) was issued the notice on May 14, 2017 for: *Failure to Follow Policy/Procedures and Violating Code of Ethics and Business Conduct.* A description of the incident stated: *On the evening of May 14 and 15, 2017, Officer* (b) (6), (b) *was assigned to Unit 7A (Restricted Housing Unit) where he failed to make his required 30 minute detainee observation rounds, per CoreCivic policy 10-100 section J Supervisor paragraph 1. Officer* (b) *then falsified document 10-1F, indicating that he made the required observation rounds.* (Attachment D)

On November 2, 2017, DHS OIG interviewed (b) (6), (b) (7) stated he was formerly an officer at SDC for the last six years. (b) added that he began his employment at SDC on the second shift, 2pm -10pm then moved to the third shift, 10pm-6am, which was the shift in which the death of Jimenez-Joseph occurred. (b) indicated he recalled the incident and recalled that (b) (6), (b) (7)(C), CoreCivic, Lumpkin, GA, was the shift supervisor that night and that (b) was assigned to housing unit 7A, which was the segregation unit. (b) advised he was routinely assigned to the segregation unit and had received special training to work in that unit. (b) stated he recalled leaving unit 7A three times during his shift the night of the incident. (b) said he left one time to get a detainee clothing, left another time to speak to (b) (6), and another time to take a detainee to unit 5. (b) was not sure if leaving the unit was against policy but stated there was one other officer in unit 7A when he left the unit to perform the other duties. (b) added that the other officer present in the unit was a "one on one officer," which has to remain outside a detainee's cell for continuous observation and does not assist with other duties or making rounds.

(b) advised that he was aware that rounds had to be conducted every 30 minutes; however, he indicated he was trying to cover multiple jobs which resulted in him not being able to make all the required rounds. Resultantly, (b) stated he falsified the required log indicating that he had performed the required rounds when in fact he had not. (b) was shown a document previously obtained by DHS OIG labeled Confinement Watch Log, 10-1, and dated May 14, 2017. (b) confirmed that the log was the one completed by him the night of the incident and verified that his initials were depicted on the document. According to the document, (b) indicated he performed rounds at "2208, 2236, 2304 and 2332, 0000, 0028 and 0045" (b) admitted to and believed he falsified one of the seven entries notated but could not be sure which entry was false. (b) stated that he was not ordered by anyone at SDC to falsify the document and stated that he was "just trying to cover himself." (b) indicated that inadequate staffing on his shift put him in the position to have to falsify the document and due to the multiple other duties he performed the night of the incident he could not perform the rounds as required. [Agent's Note: the segregation staffing model provided by CC indicated that the first shift (6am-2pm) has one employee in the control room and three on the floor; the second shift (2pm-10pm) has one employee in the control room and two on the floor and the third shift (10pm-6am) has one employee in the control room and one on the floor.] (b) opined that the segregation unit needs four people at all times and the third shift is the only shift that is inadequately staffed. (b) advised he

has complained to management about the inadequate staffing on his shift and was told that the regulations state only one person was needed. (Attachment E)

On March 6, 2018, DHS OIG completed a review of the following documents received from IHSC: Mortality Review for Jean Carlos Alfonso Jiminez Joseph, (b) (6), (b) (7); Root Cause Analysis Action Plan Feedback and Root Cause Analysis and Action Plan Framework Template.

The following executive summary and mortality findings provided a synopsis of the detailed reports reviewed. Due to the level of detail in the report examined a separate synopsis will not be made, reference should be made to the specific document for additional information.

Executive summary: *Mr. Jean Carlos Alfonso JIMENEZ Joseph, a 27-year-old Panamanian male, was in ICE custody from March 2, 2017 to May 15, 2017. Prior to intake into ICE custody, he had a prior history of suicide attempts and psychiatric hospitalizations for psychosis (i.e., a symptom of serious mental disorders characterized by an impaired relationship with reality; psychotic persons may have either hallucinations or delusions), paranoia (a mental condition characterized by delusions of persecution or exaggerated self-importance), schizophrenia (i.e., a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and auditory hallucinations (i.e., hearing internal words or noises that have no real origin in the outside world and are perceived to be separate from the person's mental processes) that were sometimes command in nature (i.e., the contents of the hallucinations can range from innocuous to commands that cause harm to self or others). During the course of his custody, he was treated for psychosis with auditory hallucinations and schizoaffective disorder, bipolar type (i.e., a mental disorder in which a person experiences a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). On May 15, 2017, custody officers found Mr. JIMENEZ in his Stewart Detention Center (SDC) special management unit (SMU) cell unresponsive and hanging with a sheet tied around his neck. Subsequent resuscitation efforts were unsuccessful, and he was pronounced dead in a local emergency department.*

Mortality finding: *Based on the overall findings of this review, Mr. JIMENEZ's progressively deteriorating mental health status warranted timely behavioral health provider (BHP) telephone consultations with a psychiatrist and/or referral to a psychiatrist. Although it is reasonable to consider monitoring a patient with a known mental health disorder in a detention facility, Mr. JIMENEZ's symptoms were becoming progressively worse, his prescribed psychotropic regimen was not at a therapeutic level, and SDC did not have adequate psychiatry resources to appropriately manage Mr. JIMENEZ. Therefore, it would have been best practice to refer Mr. JIMENEZ to an in-patient psychiatric facility or another detention facility with adequate psychiatry services.*

Additionally, a detailed summary of additional health care delivery/program weaknesses were identified in the following areas during the review: Medical pre-screening prioritization; Prescribing continuity medications upon intake into SDC; Timely medical intake screening for PRI-1 referral; Suicide Prevention and Intervention; Identification and notification of detainees with serious mental health conditions; Timely access to necessary and appropriate mental health care; Special Management Unit (SMU); Sufficient number of

appropriately trained and qualified mental health staff; Communication regarding serious mental illness and special vulnerabilities; Access to emergency medical services. See attached Mortality Review document for specific recommendations made in those areas identified. (Attachment F)

[Agent's Note: the Mortality Review document reviewed was labeled "Pre-decisional—for Internal Discussion Only/Not for Distribution."]

This summary is submitted in consideration of indicting (b) for the following violations:

- Title 18 USC Section 1001 (False Statements, Concealment)

ATTACHMENTS:

A	Memorandum of Activity – Records Review/SDC Segregation Policy
B	Memorandum of Activity – Review of GBI Documents
C	Memorandum of Activity – Audit Review – CC SDC Health Unit
D	Memorandum of Activity – Personal Contact (b) (6), (b)
E	Memorandum of Activity – Personal (b) (6), (b) (7) (b)
F	Memorandum of Activity – Review of IHSC Records

EXHIBIT #19

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

MEMORANDUM OF ACTIVITY

Type of Activity: Other: USAO Declination

Case Number: I17-ICE-ATL-15215	***Case Title:*** (b) (b)

On March 20, 2019, (b) (6), (b) , Special Agent (SA), U.S. Department of Homeland Security (DHS), Office of Inspector General (OIG), Atlanta, GA, met with (b) (6), (b) , Assistant United States Attorney (AUSA), United States Attorneys' Office (USAO), Middle District of Georgia, Columbus, GA, regarding the investigation pertaining to the death of Jean Carlos Jimenez-Joseph (A#: (b) (6), (b)), who committed suicide by hanging himself in his detention cell at Stewart Detention Center (SDC), Lumpkin, GA. On November 2, 2017, DHS OIG obtained a confession from (b) (6), (b) (6), (b) (6), (b) (7)(C)), CoreCivic, SDC, who admitted to he falsified a round count document involving Jimenez-Joseph. Reference is made to a previous report dated May 25, 2018, in which a prosecution summary was provided to (b) (6), (b) , (b) (6), (b) (7) , Middle District of Georgia, United States Attorney's Office, Columbus, GA, for review and a prosecutorial decision.

(b) advised that the USAO had declined to prosecute this matter. This case will be closed.

(b) (6), (b) (7)(C)

IMPORTANT NOTICE
This report is intended solely for the official use of the Department of Homeland Security, or any entity receiving a copy directly from the Office of Inspector General, and is disseminated only on a need to know basis. This report remains the property of the Office of Inspector General, and no secondary distribution may be made, in whole or in part, outside the Department of Homeland Security, without prior authorization by the Office of Inspector General. Public availability of the report will be determined by the Office of Inspector General under 5 U.S.C. 552. Unauthorized disclosure of this report may result in criminal, civil, or administrative penalties.

Office of Inspector General

Logged In As: (b) (6)

Wed

Investigations

Role: Assistant Spe

Investigation # - I1715215 Investigation Title - (b) (6) (b) (7)(C) ; ICE Status - Closed Agent - (b) (6)

Action

Action	Referred - No Reply
Referred To	DHS OIG Program Office / Agency *
Agency Referred To	DHS ICE OPR - ICE, Office of Professional Responsibility *
Referred Date	07/31/2019 *
Date Closed	7/31/2019 *

Office of Inspector General

Logged In As: (b) (6), (b) (7)

Wednesday, May 17, 2017

Role: Administrative Officer

Investigations

Investigation # - I17-ICE-ATL-15215	Investigation Title - FNU LNU; ICE; Lumpkin, GA	Status - Open	Agent (b) (6), (b)

Initiate Investigation

Investigation Title FNU LNU; ICE; Lumpkin, GA

Individual or Joint Agency Investigation *

Joint Agency *

Other Reference Number C1715215

OIG Office *

Investigation Type ☐ Civil ☑ Criminal ☑ Administrative *

Primary Agent *

Date Assigned 5/17/2017 *

Date Complaint Received 5/15/2017 *

Received By *

Received From

DHS Agency Affected *

Allegation Priority Level Level 3

Allegation Category *

Allegation *

Allegation Detail

Narrative On May 15, 2017, DHS OIG was notified by ICE OPR that detainee Jean Carlos Jimenez-Joseph, A# (b) (6), had allegedly hung himself in his cell located at Stewart Detention Center (SDC), located in Lumpkin, GA. Efforts were made to revive the detainee by SDC staff and the detainee was transported to Phoebe Sumpter Medical Center where the detainee was pronounced deceased upon arrival. *

Dollar Loss $0.00

Privacy Violation Complaint ☐

* Required Field

Homeland Security

Office of Inspector General

Logged In As: (b) (6), (b) (7)

Wednesday, May 17, 2017

Role: Administrative Officer

Investigations

Investigation # - I17-ICE-ATL-15215	Investigation Title - FNU LNU; ICE; Lumpkin, GA	Status - Open	Agent (b) (6), (b)

Initiate Investigation

Investigation Title FNU LNU; ICE; Lumpkin, GA

Individual or Joint Agency Investigation Joint *

Joint Agency U.S. Immigration and Customs Enforcement - Office of Profes *

Other Reference Number C1715215

OIG Office Atlanta, GA *

Investigation Type ☐ Civil ☑ Criminal ☑ Administrative *

Primary Agent Moon, Jason *

Date Assigned 5/17/2017 *

Date Complaint Received 5/15/2017 *

Received By Email *

Received From [CATSOFF - U.S. Immigration and Customs Enforcement - Office of Professional Responsibility (DHS)]

DHS Agency Affected ICE - U.S. Immigration and Customs Enforcement (DHS) *

Allegation Priority Level Level 3

Allegation Category Miscellaneous *

Allegation Non-Criminal Misconduct *

Allegation Detail Depth Investigation

Narrative On May 15, 2017, DHS OIG was notified by ICE OPR that detainee Jean Carlos Jimenez-Joseph, A# (b) (6), had allegedly hung himself in his cell located at Stewart Detention Center (SDC), located in Lumpkin, GA. Efforts were made to revive the detainee by SDC staff and the detainee was transported to Phoebe Sumpter Medical Center where the detainee was pronounced deceased upon arrival. *

Dollar Loss $0.00

Privacy Violation Complaint ☐

* Required Field

SA (b) (6), (b) (7)(C)
SA

(b) (6), (b) (7)(C)

11/2/17
25:47 pm

- Previously interviewed by CBI
- 3rd Shift at time of incident
- 6 years
- 3 years Capt.
- 2 years LT.
- started as a LT. (b) (6), (b) (7)(C)
- Hood (AC) Chief (His supervisor).
- On 3rd shift approx 4 mo. prior to incident.
- 2nd vs. 3rd Lack of Movement as it relates to movement.
- Biggest is lesser staffing
- Not aware of complaints by employees regarding staffing issues.
- Employee is required to let him know if they need coverage to cover them.
- He has added additional personnel following incident
* Since incident has placed an extra body.
- Doesn't recall Mr. Yuns asking for telling him he needed to leave to do other jobs.
- Advised no one has complained to him.

(11)

* NIGHT of INCIDENT:

- MR. [redacted] Radio emergency (suicide).
- Came from day rounds to unit 7A.
- Saw JUNIOR on ground.
- Once he saw what happened, contacted staff to give emergency orders.
- EMS had already been contacted.

* 1ST time seeing a situation like this.
- On night of incident does not recall MR. [redacted] asking him to be relieved to do other work.
* LT. [redacted] was on scene as well.
- [redacted] Resigned after incident, not sure how long.
- Doesn't know who was disciplined as a result of incident.

* At time of incident staffing #'s were way down.
* After incident staffing #'s have come up!

END 6:17pm

11/2: Medical meeting 2:39 pm

Capt Martin -

when occ:

[redacted] [redacted]

3rd shift alarm capt. 6 yrs.
capt 3 yrs
1# - 2 yrs chief

Capt. Asst Chief [redacted] c̄ [redacted]

4 months

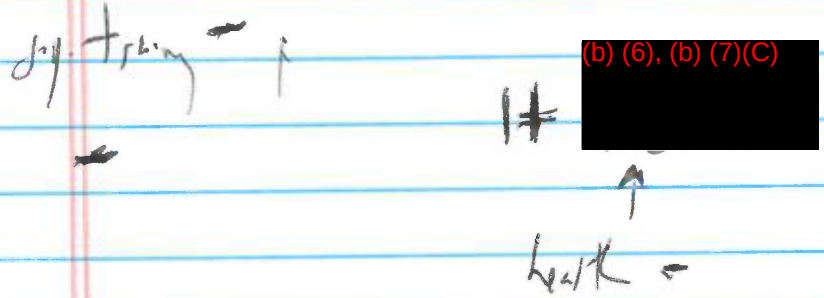
Issue - none 7A

A -
no - stuff to [illegible]

[redacted] Complacency

M

w


(b) (6), (b) (7)(C)

1:30pm Meeting / Health

ICE
(b) (6), (b) (7)(C)

C.C
POlock
Nurse Manager
PHARMACIST
CONTRACT COORDINATE

FORMAT

- Funding & Corrective Actions...
-

* 500 detainees per Mental Health person.

*=> (b) (6), (b) (7)(C) : Host at all info conducted remedies, inspections, etc.

SA (b) (6), (b) (7)(C) [redacted]

ICE & CoreCivics - Medical

11/2/17
1:44 PM

* Discussed Jumper CoreCivics history
- Priority #1 (Immediately seen). Was it seen for 5 hrs?

- Changed pre-screening policy.
- Issue with group based housing (regarding Mes dosage)
  * needs to verify

- No suicide assessment was done. There is a template that was not followed.

- Issue with suicide watch policy regarding watching suicide watch person.
  * 24 hrs minimum.
  * Jumper taken off before without proper approvals
    ⇒ OUTSIDE OF policy

-

* There have been issues with 72 hour follow up with suicide watch individuals.

- 4/7/17: Jumper advised hearing voices.
  → was said to be stable, This is slight off not being stable.

- Failed after Jumper displayed many issues of instability to increase Mes dosage.

- Jimmer was dropped from previous Mental Health Appmt. Reseached for 3 weeks Later. Same day Jimmer committed suicide.

- The quality/practices of mental Health provider in question!

- May 10th Jammer found in SCG, pounding head against wall. Reported hearing voices. Thoughts of killing himself.
  * 5 days Before.
  * Nothing happened!!! *

- Jimmer was not added to SIGNIFICANT Mental Health Lists.

* After suicide - Medical response okay...

** Check into Jammer jumping from 2nd level to attempt suicide...
→ Jumped from 2nd Tier.

⇒ Med staff was not told Jammer attempted suicide by jumping off 2nd Tier by COs/CVICS...

⇒ may be some descrepencies!

* Weekly Seg Meeting - Has since been implemented by former Warden Spivey.

END 2:50pm

(2)

SA (b) (6), (b) (7)(C)
SA [redacted]

- CoreCivics Attorney 1:06 pm
(b) (6), (b) (7)(C) [redacted] ; pork local

⇒ CoreCivics Employee ⇐

- Started 2016
- Officer
- Works on 1st shift was on 2nd shift
- Shift change: Approx 7/8 months
- Timeline incident: 2nd Shift Assigned
- Timeline incident happened on 3rd shift
- Duties: Assigned 7 Broda (Holding cell detainees who haven't been housed
- 7A segregation
- Hasn't worked seg on a regular.
- Doesn't have the certifications.
- Went to 7A after incident.
- Went to 7A to grab equipment (Broom, etc.) For cleaning.

- Assisted after incident with 7A count.
- Not sure who was assigned to 7A (Detention Officers).
- Doesn't recall dayup count before incident.
- 7B no dogs needed for count.
- Believes it was a normal day.
- He was only person assigned to 7B.

(1)

- Received call for emergency at 7A.
- Witnessed coworker injury from sprinkler head.
- Was interviewed by coworkers INVEST, Lowes and attorney.
- After incident, received training on mental health determinees.

1:23 PM

11/22/14: [illegible] by CCA (b) (6), (b) (7)(C) [redacted] bringing [illegible] into SDC - 6 detainees [illegible] to

Inmate (b) (6), (b) (7)(C) [redacted] [illegible] ([illegible]) [illegible] ([illegible])

[illegible] for detainee [illegible]

[illegible] - & [illegible] to [illegible] together, [illegible] Messer the [illegible] Smith [illegible]

12/3/14 CI: (b) (6), (b) (7)(C) [redacted] [illegible] by DHS: confirmed (b) (6), (b) (7)(C) [redacted] involved

12/3/14 [illegible] of (b) (6), (b) (7)(C) [redacted] detainee, (b) (6), (b) (7)(C) [redacted] involvement

Messer [illegible] to Smith [illegible], [illegible] to assist

[illegible] to Smith [illegible] SDC [illegible] Messer [illegible] Anderson

[illegible] [illegible] to [illegible] meeting [illegible] exchange

[illegible] Anderson [illegible] [illegible] of [illegible]

[illegible] (Security of Facility)

[illegible]

Completed Smith statement 11/17 [illegible] meeting

12/5/14: AUSA (b) (6), (b) [redacted] [illegible] (b) (6), (b) (7)(C) [redacted]

12/5/14: SDC [illegible] / telephone [illegible]: [illegible] Messer [illegible] (b) (6), (b) (7)(C) [redacted] (b) (6), (b) (7)(C) [redacted]

1/5/15: AUSA [illegible] declines prosecution of detainees & Smith: further investigative efforts halted

[illegible] by Messer [illegible] Smith [illegible]

12/5/15 [illegible]

12/12/15: [illegible] statements by (b) (6), (b) (7)(C) [redacted] [illegible] for 15 months

6/2/15: [illegible] (b) (6), (b) (7) [redacted] [illegible] [illegible] July 2015

6/6/15: AUSA (b) (6), (b) (7)(C) [redacted] [illegible] of [illegible], [illegible]

6/24/15 Subpoena issued for Anderson [illegible] by [illegible] (b) (6), (b) (7)(C) [redacted]

10/15/15 7 calls to (b) (6), (b) (7)(C) [redacted] & (b) (6), (b) (7)(C) [redacted]

[illegible] letter [illegible] to Anderson - no response

(b) (6), (b) (7)(C) [redacted]

Mar 17 [illegible] early 2016 - officer - 1st shift, was [illegible]

7-4 month 2nd shift

3rd shift 10-6am

3 7B - [illegible]

7A -

[illegible] - 2C -

[illegible] -

[illegible] [illegible] [illegible] -

[illegible] - ICE Mandarin

(b) (6), (b) (7)(C) [redacted]

Spring

16. The other - [illegible]

[illegible] (b) (6), (b) (7)(C) [redacted]

(b) (6), (b) (7)(C)

4:30pm

- OFFICER
- started cell 2ND floor to 3RD
- ON 3RD shift (10-6am) night of suicide
- OFFICER [redacted] in control room
- CPT. [redacted] on shift.
- Night of incident assigned to 7A (SEG).
- 7B sick/vacation was assigned
- During count 2 people
- During count of 7A & 7B, there was a brief time no officer on deck.
- Left to get detainee clothing from property (1ST)
- Left to speak with CPT. Martin to let him know where he was going. (2ND)

* Not sure of order

- Left a third time to take detainee to cell #5
- Was not ordered to falsify SEG Clock Logs
- Admitted he was trying to cover himself.
- Advised he feels that he was trying to cover multiple JOIs.
- Stated SEG needs 4 people at all times.
- on 1ST & 2ND SHIFT 7A is adequately staffed.
- Advised he got behind on a regular because of staffing issues.

(1)

- Has complained, but was told that regs state only one person is needed.
- Had been through training for SOG
- Meeting: Warden Spivey, Assist Warden pollock *NO HR in Meeting.
- Was advised before Meeting to write statement by Warden.
- Meeting with Warden, told to write another statement.
- After Meeting with Warden, he was interviewed by GBI.
- Was placed on admin leave.
- 6/29/17: called to Meet at CoreCivics. was Fired. (Warden Spivey, pollock, HR).

* Facility ~~Staff~~ is not being run properly.
- Stated wasn't given any employee rights before being told to write statements.

- Can use count check as one of Rounds checks in SEG (7A)

- out of four only ① one was written in.
- Has complained about inadequate staffing.

* Advised he was okay not to make a statement..

END 5:00pm

1/1

[redacted] - chaplain care
3 days
Bldg... work here
draft - Friday night, wait ...

LCSW - [redacted] - transferred end of Sept.
[redacted] now
Still ... ... stuff

things to improve on

1:30 pm meeting
W... plan

(X)

didn't do
Suicide risk assessment form
was conducted ...

[redacted] no follow-up
Suicide watch

FF ...

Mil. level problem - issue ... ... roles

[redacted] - clinical director GS
[redacted] Chona - phsychologist - GS - video telepresence only

| mental health provider / 2000 support ... 3

Ford [redacted] - ... friend

communication - Feel have been more comms.
1) Nurse - [redacted] ... to be ... - week later
banging head, voices telling me to kill myself, should have been on suicide watch

didn't take him seriously

2) Calvary - d ... not the standard ... ...

(b) (6), (b) (7) (C)

1st Shift 0600 - 1400

1 Control room
3 Floor

2nd Shift 1400 - 2200

1 Control room
2 Floor

3rd Shift 2200 - 0600

1 Control room
1 floor

1 AM
2:30 AM
3:30 AM
8:00 AM
3:00 P.M.
7:30 P.M.
11:00 PM

Count Time
PSDC

[redacted] Sup. DDO

main responsibility
Fell/Meal - Stood up

FLATT : QA manager - ++

[redacted] 4 days - overt 3 500 / guidelines
no policy
++ Capt. [redacted]
"we can't fire a contractor"
LPN - check w/ lab B0/22

tried to fire Anderson - HQ's 15 [illegible]
put her clear back in closet
Ms. Jackson - contract coordinator - [illegible] - switched to STG - position
Maximum
* Contract other Rep: Capt HQ

Jt [redacted] - LCSW

1/2

Suicide watch 24
constant watch - clothing
mental health observation 15 min meals - stipend
plan pay

best on
assessment

Cmid [redacted]

HD 2 months -

7/7

[redacted]

7A -

constant watch -
Suicide watch -
straight 15 min & half hour

C/O beds - not watching full
15 25
no more than 45 min
apart on irregular schedule

dinner - 30 mins

CCA policy - 30 mins - 10-100
2-12 - PBNDS 2011

no known reason - maybe it pulled off

OPR did interview she would w/o

2x an hour but no more than 45 mins lapse

[redacted] Lt. at time of incident
Asst. Shift Supervisor
resigned
verify w/ HR if terminated - disciplining him & Lt
& looking it

Asst. Chief - Freddie Hand yelling at him
Pollock yelling at him

[redacted] still here

[redacted] terminated - OIC that fired him

get roster of what was assigned that night
& what was occurred

[redacted] Sitting at desk in 7A

1/1 going on in 7A

43
12:11
32

11:58:13 Signal X

12:11:02 Signal again X

12:13 am

12:17 looking in [redacted] cell for

(12:43 7A day) → goes there

+ [redacted] start log

V/I
did he hear anything

12:44 7A search - First enter cell

Mobility Review (+) w/ [redacted]
Noted [redacted] Hair down
draft 7HSC Capt [redacted]

[redacted] [redacted] [redacted]

Hark [redacted]

① Manik envelope - Alert - Noted envelope found in his cell
addressed to Calvera

6-7-37
Blackburn 4473

albuterol

8am 3p
cont time: 11p-1am. ck- count = welfare ck

2 ppl to speak
to initial officer

(b) (6), (b) (7)(C) [redacted]

(b) (6), (b) (7)(C) [redacted]

cont count

count ~~20~~ 11:00 1st ck

(b) (6), (b) (7)(C) [redacted]

10:14 1st ck

11:02 2nd - count rounds 20

11:25 3rd

12:43 4th

11:51 1st ck

12:11 2nd ck

12:44 Sing 2nd ck

(b) (6), (b) (7)(C) [redacted] Captain

hej w/ Chuy

why

10:47 - noon w/ pal

Get copy of initial report

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

Washington, DC 20528 / www.oig.dhs.gov

CASE CLOSING CHECKLIST

General – ALL CASES

CASE NUMBER: I17-ICE-ATL-15215

Yes	N/A	
☑	☐	Complaint Document Form
☑	☐	ROI with Exhibits or AROI (no exhibits)
		Case Opening Document Transmittal Memo (N/A with AROI) Memorandum of Activity (MOAs)
☑	☐	Agent's Notes/Correspondence/Record Checks/Miscellaneous Reports/Written Statements/Advice of Rights Forms, etc.
☐	☑	FBI Case Notification Letter
☐	☑	Disposition of Evidence/Personal Property
☐	☑	Destruction or Other Disposition of Grand Jury Material
☑	☐	EDS Indexing Completed
☑	☐	Declination Letter from USAO
☐	☑	Copies of Subpoenas – Other Miscellaneous Court Documents

JUDICIAL CASES ONLY

☐	☑	Copies of Warrants/Indictments
☐	☑	Fingerprints/Photos/Personal History of Offender
☐	☑	FBI Standard Form 84 (Report of Arrest Disposition)
☐	☑	FBI Rap Sheet

OTHER

☐	☑	Disposition of Confidential Informant
☐	☑	Victim/Witness Referrals/Report
☑	☐	Case Review Worksheet
☐	☑	Referred for Suspension/Debarment

Case Agent Signature and Date: (b) (6), (b) (7)(C) 7/26/19

Special Agent in Charge Signature and Date: (b) (6), (b) (7)(C) 7/31/19

INV FORM-14

Department of Homeland Security
Office of Inspector General
Office of Investigation

Case Progress Worksheet

Date of Review: 04-22-19

Supervisor: (b) (6),

Case Agent: (b) (6), (b)

Case Number: I17-15215

Case Title: Fred Wims

Primary Case Category: Civil Rights/Civil Liberty

Date Case Initiated: 05-17-17

# of Days Opened: 705

Date Range of Review: Jan 15, 2019 to Apr 22, 2019

DHS Employee Title: Contract Officer (former)

DHS Employee Status: Terminated

TO BE COMPLETED BY THE CASE AGENT

MOA# of Last Investigative Activity: 26

Are All Approved Non-GJ MOAs Uploaded into EDS? (•) Yes ( ) No

Ending MOA# From Previous Review: 22

Outstanding MOA #'s that need uploading: 0

Number of MOAs Approved Since Last Review: 4

Is the Investigative Plan Current? (•) Yes ( ) NO

Date of Last Investigative Activity: 03-20-19

Summary of Current Status/ Investigative Activity to Date:

DHS OIG was notified of a detainee death at SDC. GBI processed the involved cell and ruled the cause of death to be a suicide. Site interviews of personnel involved have been conducted and determinations have been made that ICE policy was not followed related to suicidal detainees. A confession was obtained from a CC employee for falsification of a round check internal document. The case was declined by the USAO, Middle District of GA, on 3/20/19. No further investigation is needed and the case will be closed.

Anticipated Investigation Milestone(s):

1. Close--ROI under review
2.
3.
4.
5.
6.
7.

TO BE COMPLETED BY THE REVIEWING SUPERVISOR

Supervisor's Comments and Guidance on Progress and Future Activity:

1. Complete edits on ROI, prepare case for closing
2.
3.
4.
5.
6.

Supervisor's Signature: (b) (6), (b) (7)(C)

Date:

Department of Homeland Security
Office of Inspector General
Office of Investigation

Case Progress Worksheet

Date of Review: 10-02-18

Supervisor: (b) (6), (b) (7) Case Agent: (b) (6), (b) Case Number: I17-15215

Case Title: (b) (6), (b) Primary Case Category: Civil Rights/Civil Liberty

Date Case Initiated: 05-17-17 # of Days Opened: 503 Date Range of Review: Jul 20, 2018 to Oct 2, 2018

DHS Employee Title: Contract Officer (former) DHS Employee Status: Terminated

TO BE COMPLETED BY THE CASE AGENT

MOA# of Last Investigative Activity: 19

Are All Approved Non-GJ MOAs Uploaded into EDS? (•) Yes ( ) No

Ending MOA# From Previous Review: 1

Outstanding MOA #'s that need uploading: 0

Number of MOAs Approved Since Last Review: 1

Is the Investigative Plan Current? (•) Yes ( ) NO

Date of Last Investigative Activity: 09-05-18

Summary of Current Status/ Investigative Activity to Date:

DHS OIG was advised of a detainee death at SDC. The GBI processed the involved cell and ruled the cause of death to be a suicide. Site interviews of personnel involved have been conducted and determinations have been made that ICE policy was not followed related to suicidal detainees. A FOIA request has been received, a response from OIG has been completed. A confession was obtained from a CC employee for falsification of a round check internal document. A pros summary was sent to the USAO. Additional documents were requested by the USAO during this period and the case continues to be under review.

Anticipated Investigation Milestone(s):

1. Await charging decision/obtain reg. update
2.
3.
4.
5.
6.
7.

TO BE COMPLETED BY THE REVIEWING SUPERVISOR

Supervisor's Comments and Guidance on Progress and Future Activity:

1. await AUSA decision
2. proceed w/ IP as warranted
3. if declined, begin closing process
4.
5.
6.

Supervisor's Signature: (b) (6), (b) (7)(C) [redacted] Date: 2018-10-03

Department of Homeland Security
Office of Inspector General
Office of Investigation

Case Progress Worksheet

Date of Review: 07-17-18

Supervisor: (b) (6), (b) (7) Case Agent: (b) (6), (b) Case Number: I17-15215

Case Title: (b) (6), (b) Primary Case Category: Civil Rights/Civil Liberty

Date Case Initiated: 05-17-17 # of Days Opened: 431 Date Range of Review: Apr 20, 2018 to Jul 17, 2018

DHS Employee Title: N/A DHS Employee Status: N/A

TO BE COMPLETED BY THE CASE AGENT

MOA# of Last Investigative Activity: 18

Are All Approved Non-GJ MOAs Uploaded into EDS? (•) Yes ( ) No

Ending MOA# From Previous Review: 15

Outstanding MOA #'s that need uploading: 0

Number of MOAs Approved Since Last Review: 3

Is the Investigative Plan Current? (•) Yes ( ) NO

Date of Last Investigative Activity: 07-12-18

Summary of Current Status/ Investigative Activity to Date:

DHS OIG was advised of a detainee death at SDC. The GBI processed the involved cell and ruled the cause of death to be a suicide. Site interviews of personnel involved have been conducted and determinations have been made that ICE policy was not followed related to suicidal detainees. A FOIA request has been received, a response from OIG has been completed. A confession was obtained from a CC employee for falsification of a round check internal document. A pros summary was sent to the USAO and is currently being reviewed by the criminal chief.

Anticipated Investigation Milestone(s):

1. Notify USAO of recent suicide incident
2. Await USAO decision
3. Proceed with closure or indictment upon decision
4.
5.
6.
7.

TO BE COMPLETED BY THE REVIEWING SUPERVISOR

Supervisor's Comments and Guidance on Progress and Future Activity:

1. Add Criminal Disposition and relevant info as case
2. was submitted for decision to AUSA
3. Upload MOA #18 to EDS
4. Replace MOA#13 w/ signed copy
5.
6.

Supervisor's Signature: (b) (6), (b) (7)(C) Date: 2018-07-17

Department of Homeland Security
Office of Inspector General
Office of Investigation

Case Progress Worksheet

Date of Review: 04-23-18

Supervisor: (b) (6), (b) (7) Case Agent: (b) (6), (b) Case Number: I17-15215

Case Title: FNU, LNU, Lumpkin GA Primary Case Category: Civil Rights/Civil Liberty

Date Case Initiated: 05-17-17 # of Days Opened: 341 Date Range of Review: Jan 20, 2018 to Apr 23, 2018

DHS Employee Title: N/A DHS Employee Status: N/A

TO BE COMPLETED BY THE CASE AGENT

MOA# of Last Investigative Activity: 15

Are All Approved Non-GJ MOAs Uploaded into EDS? (•) Yes ( ) No

Ending MOA# From Previous Review: 13

Outstanding MOA #'s that need uploading: 0

Number of MOAs Approved Since Last Review: 2

Is the Investigative Plan Current? (•) Yes ( ) NO

Date of Last Investigative Activity: 03-06-18

Summary of Current Status/ Investigative Activity to Date:

DHS OIG was advised of a detainee death at SDC. The GBI processed the involved cell and ruled the cause of death to be a suicide. Site interviews of personnel involved have been conducted and determinations have been made that ICE policy was not followed related to suicidal detainees. A FOIA request has been received, a response from OIG has been initiated. A pros summary will be submitted to document OIG's findings to the USAO for case evaluation.

Anticipated Investigation Milestone(s):

1. Submit pros summary
2. Respond to FOIA
3.
4.
5.
6.
7.

TO BE COMPLETED BY THE REVIEWING SUPERVISOR

Supervisor's Comments and Guidance on Progress and Future Activity:

1. Submit summary to USAO for review/decision
2. Response submitted for FOIA request/completed
3. After USAO decision, draft ROI for supervisory review
4.
5.
6.

Supervisor's Signature: (b) (6), (b) (7)(C) [redacted] Date: 2018-04-23

Department of Homeland Security
Office of Inspector General
Office of Investigation

Case Progress Worksheet

Date of Review: 01-26-18

Supervisor: (b) (6), (b) (7) Case Agent: (b) (6), (b) Case Number: I17-15215

Case Title: FNU, LNU, Lumpkin GA

Primary Case Category: Civil Rights/Civil Liberty

Date Case Initiated: 05-17-17 # of Days Opened: 247 Date Range of Review: Oct 20, 2017 to Jan 26, 2018

DHS Employee Title: N/A DHS Employee Status: N/A

TO BE COMPLETED BY THE CASE AGENT

MOA# of Last Investigative Activity: 13

Are All Approved Non-GJ MOAs Uploaded into EDS? (•) Yes ( ) No

Ending MOA# From Previous Review: 4

Outstanding MOA #'s that need uploading: 0

Number of MOAs Approved Since Last Review: 9

Is the Investigative Plan Current? (•) Yes ( ) NO

Date of Last Investigative Activity: 11-02-17

Summary of Current Status/ Investigative Activity to Date:

DHS OIG was advised of a detainee death at SDC. The GBI processed the involved cell and ruled the cause of death to be a suicide. Site interviews of personnel involved have been conducted and determinations have been made that ICE policy was not followed related to suicidal detainees. Resultantly, additional investigative work and additional interviews will be conducted. This investigation is ongoing.

Anticipated Investigation Milestone(s):

1. Continue field investigation
2. Complete additional staff interviews
3.
4.
5.
6.
7.

TO BE COMPLETED BY THE REVIEWING SUPERVISOR

Supervisor's Comments and Guidance on Progress and Future Activity:

1. Continue w/ employee interviews at SDC
2. Obtain relevant documents for review as necessary
3. Continue w/ investigative plan
4.
5.
6.

Supervisor's Signature: (b) (6), (b) (7)(C) [redacted]

Date: 2018-01-26

Department of Homeland Security
Office of Inspector General
Office of Investigation

Case Progress Worksheet

Date of Review: 10-20-17

Supervisor: (b) (6), (b) (7) Case Agent: (b) (6), (b) Case Number: I17-ICE-ATL-15215

Case Title: FNU, LNU, Lumpkin, GA Primary Case Category: Civil Rights/Civil Liberty

Date Case Initiated: 5/17/2017 # of Days Opened: 156 Date Range of Review: Jul 25, 2017 to Oct 20, 2017

DHS Employee Title: N/A DHS Employee Status: N/A

TO BE COMPLETED BY THE CASE AGENT

Number of MOAs Approved Since Last Review: 1

Are All Approved Non-GJ MOAs Uploaded into EDS? (•) Yes ( ) No

Number of Outstanding MOAs that are pending approval: 0

Outstanding MOA #'s that need uploading: 0

Number of Investigative Activity Since Last Review: 3

Is the Investigative Plan Current? (•) Yes ( ) NO

Date of Last Investigative Activity: 9/13/2017

Summary of Current Status/ Investigative Activity to Date:

DHS OIG was advised of a detainee at SDC that is believed to have committed suicide. The GBI has processed the involved cell and is processing the final report. DHS OIG is reviewing ICE policies and investigating the incident to determine if proper procedures were followed. A comprehensive report, videos and investigative file has been received by the GBI and is under review.

Anticipated Investigation Milestone(s):

1. Review GBI material
2. Conduct INV on-site at SDC
3.
4.
5.
6.
7.

TO BE COMPLETED BY THE REVIEWING SUPERVISOR

Supervisor's Comments and Guidance on Progress and Future Activity:

1. Review GBI reports/findings
2. Conduct interviews at SDC as discussed
3.
4.
5.
6.

Supervisor's Signature: (b) (6), (b) (7)(C) Date: 2017-10-20

Department of Homeland Security
Office of Inspector General
Office of Investigation

Case Progress Worksheet

Date of Review: 07-24-17

Supervisor: (b) (6), (b) (7) Case Agent: (b) (6), (b) Case Number: I17-ICE-ATL-15215

Case Title: FNU, LNU, Lumpkin, GA

Primary Case Category: Civil Rights/Civil Liberty

Date Case Initiated: 5/17/2017 # of Days Opened: 62 Date Range of Review: Apr 25, 2017 to Jul 24, 2017

DHS Employee Title: N/A DHS Employee Status: N/A

TO BE COMPLETED BY THE CASE AGENT

Number of MOAs Approved Since Last Review: 3

Are All Approved Non-GJ MOAs Uploaded into EDS? (•) Yes ( ) No

Number of Outstanding MOAs that are pending approval: 0

Outstanding MOA #'s that need uploading: 0

Number of Investigative Activity Since Last Review: 0

Is the Investigative Plan Current? (•) Yes ( ) NO

Date of Last Investigative Activity: 7/13/2017

Summary of Current Status/ Investigative Activity to Date:

DHS OIG was advised of a detainee at SDC that is believed to have committed suicide. The GBI has processed the involved cell and is processing the final report. DHS OIG is reviewing ICE policies and investigating the incident to determine if proper procedures were followed.

Anticipated Investigation Milestone(s):

1. Await GBI report
2. Conduct field interviews at SDC
3.
4.
5.
6.
7.

TO BE COMPLETED BY THE REVIEWING SUPERVISOR

Supervisor's Comments and Guidance on Progress and Future Activity:

1. Coordinate w/ GBI and review their final report
2. Conduct interviews at SDC
3.
4.
5.
6.

Supervisor's Signature: (b) (6), (b) (7)(C) Date: 2017-07-24

Homeland Security

INVESTIGATIVE PLAN

CASE NUMBER: I17-ICE-ATL-15215 **OFFICE:** ATLANTA

TITLE: FNU LNU; ICE **CASE AGENT:** (b) (6), (b)

Lumpkin, GA **SUPERVISOR:** (b) (6), (b)

SUMMARY OF ALLEGATION(S):

On May 15, 2017, DHS OIG was notified by ICE OPR that detainee Jean Carlos Jimenez-Joseph, A#204603723, had allegedly hung himself in his cell located at Stewart Detention Center (SDC), located in Lumpkin, GA. Efforts were made to revive the detainee by SDC staff and the detainee was transported to Phoebe Sumpter Medical Center where the detainee was pronounced deceased upon arrival.

IDENTIFY POSSIBLE VIOLATION(S) OF LAWS, RULES, OR REGULATIONS

☒ Criminal

☒ Administrative

CRIMINAL STATUTES
STANDARDS OF CONDUCT
DHS REGULATIONS
AGENCY SPECIFIC REGULATIONS
CIVIL STATUTES
ADMINISTRATIVE REGULATIONS

INVESTIGATIVE STEPS AND SCHEDULE OF WORK:

ACTION	ANTICIPATED DATE OF COMPLETION
☐ Review Complaint/Allegation/EDS Entries	TBD
☐ Database Checks	TBD
☐ Witness/Complainant Interviews	TBD
☐ Document Retrieval (IG Subpoena)	TBD
☐ Subject Interview (Advisement)	TBD
☐ Presentation to USAO	TBD

GET THE SCOOP, STRAIGHT FROM MOTHER JONES.

ENTER YOUR EMAIL SUBMIT

MADISON PAULY

Madison Pauly is the assistant editor at *Mother Jones*. Reach her at mpauly@motherjones.com.

Mother Jones *is a nonprofit, and stories like this are made possible by readers like you. Donate or subscribe to help fund independent journalism.*

Mother Jones

Copyright ©2017 Mother Jones and the Foundation for National Progress. All Rights Reserved.

Contact Us Terms of Service Privacy Policy

ICE took Jimenez into custody in March, after he served time in North Carolina for stealing a vehicle. The agency began deportation proceedings and transferred him to Stewart. In late April, Jimenez broke the the facility's rules when he jumped from a second-floor landing to the first. "You're supposed to take the stairs down," Jackson says. "He decided he was going to jump over the rail." For this infraction, Jimenez was given 20 days in disciplinary segregation—otherwise known as solitary confinement. (A United Nations expert on torture has called for the "absolute prohibition" of solitary confinement for longer than 15 days, citing studies that show just a few days in isolation can cause lasting mental damage.)

Stewart detainees have been put in segregation for less, according to allegations in a report released earlier this month by Penn State Law's Center for Immigrants' Rights Clinic and the advocacy group Project South. Drawing on interviews with more than 40 immigrants who had been held at the facility, the report's authors found that men had been sent to solitary for talking too much, not tucking in their shirts, or arguing during soccer matches. Others were put in segregation because they filed complaints, or simply because Stewart's other housing areas were full.

Once inside, segregation was "like hell," one Nigerian immigrant told the report's authors. Each day, they had to chose between making a phone call or getting an hour of recreation outside. They were not allowed to shower and had to be handcuffed and escorted each time they needed to use a toilet. Without windows, they couldn't tell if it was day or night. Their meals were smaller than the usual rations.

Five days into solitary, Jimenez "exposed himself" to a nurse, Jackson says, and his sentence was extended to 23 days. He got through 19. "He was in a cell all by himself, in an isolation cell," Jackson says. At approximately 12:45 a.m. on May 15, a detention officer found him hanging by a sheet inside the cell, unresponsive. It had been an hour since a guard had walked by his cell door, Jackson says. "They took him down from the position he was in, put him on the floor, and started lifesaving measures." Jimenez was pronounced dead at a local hospital less than two hours later. The preliminary cause of death was "self-inflicted strangulation."

(b) (6), (b) (7)

From: (b) (6), (b)
Sent: Monday, May 15, 2017 11:34 AM
To: (b) (6), (b)
Subject: FW: SEN Report - Emergency Transport and Detainee Subsequently Pronounced Dead

Importance: High

Thank you

(b) (6), (b) (7)(C)

Warning: This document is UNCLASSIFIED//FOR OFFICIAL USE ONLY (U//FOUO). It contains information that may be exempt from public release under the Freedom of Information Act (5 U.S.C. 552). It is to be controlled, stored, handled, transmitted, distributed, and disposed of in accordance with DHS policy relating to FOUO information and is not to be released to the public or other personnel who do not have a valid "need-to-know" without prior approval of an authorized DHS official. No portion of this report should be furnished to the media, either in written or verbal form.

From: (b) (6), (b)
Sent: Monday, May 15, 2017 3:57 AM
To: (b) (6), (b) (7)(C)
Subject: FW: SEN Report - Emergency Transport and Detainee Subsequently Pronounced Dead
Importance: High

FYSA

Sent with BlackBerry Work
(www.blackberry.com)

From: (b) (6), (b) (7)(C) @ice.dhs.gov>
Date: Monday, May 15, 2017, 3:51 AM
To: (b) (6), (b) (7)(C) @ice.dhs.gov>

Subject: SEN Report - Emergency Transport and Detainee Subsequently Pronounced Dead

SDC has a detainee who was transported to a hospital after successfully attempting suicide via hanging.

Per Hospital Report: Detainee was pronounced Dead at 0215 on May 15, 2017.

Name of Hospital: Phoebe Sumter Medical Center
Detainee Name: Jimenez Joseph, Jean Carlos
Alien #: (b) (6), (b)
Date of Birth: 04/20/1990
Country of Citizenship: Panam
Date of Arrival: 03/07/2017

Relevant Medical History:

- Suicidal ideation (03/08/2017)
- Suicide attempt per patient report
- Schizoaffective disorder, bipolar type
- Cannabis abuse, uncomplicated
- Unspecified asthma, uncomplicated
- Allergic rhinitis, unspecified
- Psychosis

Medications:

- Risperidone 0.5 MG Tablet, 1 tablet Orally daily at bedtime
- Docusate Sodium 100 MG Capsule, 1 capsule as needed Orally daily
- Flunisolide 25 MCG/ACT (0.025%) Solution, 2 drops in each nostril twice a day
- Albuterol Sulfate HFA 108 (90 Base) MCG/ACT Aerosol Solution, 2 puffs as needed up to four times a day

Hospitalizations:

- 3 psychiatric hospitalizations between August to December 2016 (average length of stay 2 weeks)

Cause of Death:

- Successful Suicide via hanging (presumptive diagnosis)

History of Event: (The below is per verbal reports).
On 15 may 2017, at approximately 0045, a medical emergency was called in the Special Housing Unit for a detainee who had hung himself. Upon arrival at the scene medical staff reported the detainee was laying on the ground with Core Civic officers performing CPR. Core Civic staff informed medical the detainee had hung himself with a sheet that had been tied around his neck. The sheet had already been removed prior to medical arriving on the scene. Medical staff performed a quick assessment and asked Core Civic staff if an ambulance had been requested and asked that EMS be activated if not already called. Medical staff continued CPR and connected the detainee to the AED, which indicated no shock advised and to continue CPR. CPR was continued. At approximately 0057 EMS team arrived and intubated the detainee, connected the detainee to a defibrillator and indicated the rhythm was asystole. During the course of the CPR, EMS staff gave four dosages of Epinephrine and called for a back-up EMS unit; however, as the back-up EMS unit was over 30 minutes away, the EMS team decided to transport the detainee to Phoebe Sumter Medical Center ER with Core Civic Officer in Ambulance.

Time Line:

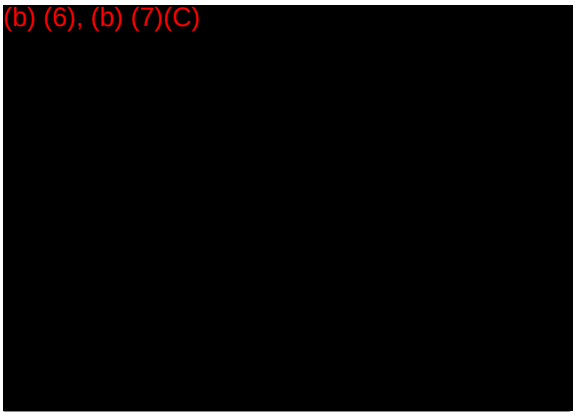
- Medical Emergency called 0045
- Medical Team on scene 0049
- Core Civic called for EMS at 0049
- EMS arrived to facility at 0057
- EMS departed facility at 0125
- Detainee pronounced dead at 0215 at Phoebe Sumter Medical Center

Notifications as of this time:

- HSA was notified at approximately 0120.
- RHSA by 0130
- CD by 0145
- AFOD by 0130
- Per AFOD the DFOD and FOD were notified by 0145.

Thank you

(b) (6), (b) (7)(C)



Warning: This document is UNCLASSIFIED//FOR OFFICIAL USE ONLY (U//FOUO). It contains information that may be exempt from public release under the Freedom of Information Act (5 U.S.C. 552). It is to be controlled, stored, handled, transmitted, distributed, and disposed of in accordance with DHS policy relating to FOUO information and is not to be released to the public or other personnel who do not have a valid "need-to-know" without prior approval of an authorized DHS official. No portion of this report should be furnished to the media, either in written or verbal form.

(b) (6), (b) (7)

From: (b) (6), (b)
Sent: Monday, May 15, 2017 11:42 AM
To: (b) (6), (b)
Cc: (b) (6), (b) (7)(C)
Subject: RE: SDC Incident

(b

The name of the GBI Agent was (b) (6), (b) (7)(C). His cell# is (b) (6), (b) (7)

Let me know if you need anything else.

Thank you

(b) (6), (b) (7)(C)

Warning: This document is UNCLASSIFIED//FOR OFFICIAL USE ONLY (U//FOUO). It contains information that may be exempt from public release under the Freedom of Information Act (5 U.S.C. 552). It is to be controlled, stored, handled, transmitted, distributed, and disposed of in accordance with DHS policy relating to FOUO information and is not to be released to the public or other personnel who do not have a valid "need-to-know" without prior approval of an authorized DHS official. No portion of this report should be furnished to the media, either in written or verbal form.

From: (b) (6), (b)
Sent: Monday, May 15, 2017 11:15 AM
To: (b) (6), (b)
Subject: SDC Incident

Hey (b)...the ASAC advised me of the SDC incident. I'm duty this week, give me a call when you can, thanks.

(b) (6), (b) (7)
Special Agent
U.S. Department of Homeland Security
Office of Inspector General
(b) (6), (b) (7)(C)
Atlanta, GA 30309